

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **16334**  
**4309**

FILED MAY 14 1953		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis, Missouri</b>		c. LENGTH OF STAY (in this place) <b>4 1/2 months</b>		c. CITY OR TOWN <b>St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Louis City Hospital</b>				e. STREET ADDRESS (If rural, give location) <b>5 5159 Raymond Ave</b> <b>2059</b>			
3. NAME OF DECEASED (Type or Print) <b>CHARLES</b>		a. (First) <b>E.</b>		b. (Middle) <b>WALKER</b>		c. (Last) <b>WALKER</b>	
4. DATE OF DEATH <b>APRIL 24, 1953</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	
8. DATE OF BIRTH <b>January 14 1890</b>		9. AGE (in years last birthday) <b>63</b>		10. IF UNDER 1 YEAR Months _____ Days _____		11. IF UNDER 1 HR. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laundry Supt</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Masonic Home</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Mt. Vernon Ills</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Riley Walker</b>		13b. MOTHER'S MAIDEN NAME <b>Unknown</b>		14. NAME OF HUSBAND OR WIFE <b>Carrie Sullens Walker</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>490-36-4573</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs Carrie Walker 5159 Raymond Ave</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.  I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>CEREBRAL ARTERIOSCLEROSIS</b>  ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.  DUE TO (b) _____  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.  INTERVAL BETWEEN ONSET AND DEATH _____							
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>334X</b>			
22. I hereby certify that I attended the deceased from <b>12-11-52</b> , 19____, to <b>4-24-53</b> , 19____, that I last saw the deceased alive on <b>4-24-53</b> , 19____, and that death occurred at <b>11:00Am.</b> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <b>Paul H. Larson, M.P.</b>				23b. ADDRESS <b>1515 Lafayette Avenue</b>		23c. DATE SIGNED <b>4-25-53</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>January 28 1953</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Laurel Hill Gardens</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis Co Mo</b>	
DATE REC'D BY LOCAL <b>APR 27 1953</b>		REGISTRAR'S SIGNATURE <b>Calvin F Feutz</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Calvin F Feutz</b>		ADDRESS <b>4828 nat Bridge Blvd</b>	

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed  
by me, or by ....., Student Embalmer No.....  
working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....

Licensed Embalmer No. 4225

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.